Please provide the following information and answer the questions below. Please note that the information you provide here is protected as confidential information.

NAME: ____
Last First Middle Initial

ADDRESS: ____
Street and Number City Province/Territory Postal Code

(if minor, please complete)
NAME OF PARENT(s)/GUARDIAN(s): ____
Last First

CONTACT INFORMATION:

HOME PHONE: ____________________ *May I leave a message? yes no*

CELL PHONE: ____________________ *May I leave a message? yes no*

WORK PHONE: ____________________ *May I leave a message? yes no*

E-MAIL ADDRESS: ____
Please note that email correspondence is not considered to be a confidential means of communication.

DATE OF BIRTH: ________________ **AGE:** __________ **GENDER:** Female Male

MARITAL STATUS:
Never Married Married Domestic Partner Separated Divorced Widowed

PLEASE LIST ANY CHILDREN AND THEIR AGE (S):
____

OTHER HEALTH/SERVICE PROVIDERS *(e.g. Primary Care Physician, Psychiatrist, etc.)***:**

NAME: ________________________________ PROVIDER ROLE: _____________________________
PHONE: _____________________

NAME: ________________________________ PROVIDER ROLE: _____________________________
PHONE: _____________________

EMERGENCY CONTACT (S):

NAME: ________________________________ RELATIONSHIP to PATIENT: ___________________

ADDRESS: ____ PHONE: _____________________

REFERRED BY: ____ **PHONE:** ____________________

Type of counselling required: Individual couple family

Insurance Coverage or Employee Assistance: YES: NO:

If yes, what form of coverage

Have you ever received counselling or therapy elsewhere?
Yes   No